FOR OHF USE

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0031807

Facility Name: LYDIA HEALTHCARE, INC.

Address: 13901 S. LYDIA (Number) ROBBINS (City) 60472 (Zip Code)

County: COOK

Telephone Number: (708) 385-8700 **Fax #** (708) 385-5642

IDPA ID Number: 36-481752

Date of Initial License for Current Owners: 1986

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve N. Lavenda **Telephone Number:** (847) 236-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	SEE ACCOUNTANT'S REPORT ATTACHED (Date)
	(Print Name and Title)	DONALD L. MAGNUSON, C.P.A.
	(Firm Name & Address)	FROST, RUTTENBERG & ROTHBLATT, P.C. 111 Pfingsten Rd. , Suite 300, Deerfield, Il 60015
	(Telephone)	(847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number LYDIA HEALTHCARE, INC. # 0031807 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	412	Intermediate (ICF)	412	150,792	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	412	TOTALS	412	150,792	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	139,919	1,143	2,613	143,675	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	139,919	1,143	2,613	143,675	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.28%

D. How many bed-hold days during this year were paid by Public Aid?
5,095 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 12/17/1986

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/17/86 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number LYDIA HEALTHCARE, INC. # 0031807 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	327,598	49,943	14,078	391,619		391,619		391,619			1
2	Food Purchase		534,467		534,467	(41,724)	492,743	(42)	492,701			2
3	Housekeeping	445,017	110,810		555,827		555,827		555,827			3
4	Laundry	46,869	42,702		89,571		89,571		89,571			4
5	Heat and Other Utilities			213,323	213,323		213,323		213,323			5
6	Maintenance	110,695	23,726	546,555	680,976		680,976	(104,451)	576,525			6
7	Other (specify):*											7
8	**TOTAL General Services**	930,179	761,648	773,956	2,465,783	(41,724)	2,424,059	(104,493)	2,319,566			8
	B. Health Care and Programs											
9	Medical Director	6,368			6,368		6,368		6,368			9
10	Nursing and Medical Records	2,223,970	121,307	75,837	2,421,114		2,421,114	(61,091)	2,360,023			10
10a	Therapy			2,351	2,351		2,351		2,351			10a
11	Activities	172,443	3,757	31,102	207,302		207,302		207,302			11
12	Social Services	371,149		19,306	390,455		390,455		390,455			12
13	Nurse Aide Training											13
14	Program Transportation			8,449	8,449		8,449		8,449			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,773,930	125,064	137,045	3,036,039		3,036,039	(61,091)	2,974,948			16
	C. General Administration											
17	Administrative	204,893		1,223,850	1,428,743		1,428,743		1,428,743			17
18	Directors Fees											18
19	Professional Services			134,027	134,027	(29,658)	104,369	(573)	103,796			19
20	Dues, Fees, Subscriptions & Promotions			47,905	47,905		47,905	(12,927)	34,978			20
21	Clerical & General Office Expenses	366,765	69,101	149,103	584,969		584,969	(126,066)	458,903			21
22	Employee Benefits & Payroll Taxes			723,278	723,278	41,724	765,002		765,002			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,009	4,009		4,009		4,009			24
25	Other Admin. Staff Transportation			1,800	1,800		1,800		1,800			25
26	Insurance-Prop.Liab.Malpractice			58,105	58,105		58,105		58,105			26
27	Other (specify):*											27
28	**TOTAL General Administration**	571,658	69,101	2,342,077	2,982,836	12,066	2,994,902	(139,566)	2,855,336			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,275,767	955,813	3,253,078	8,484,658	(29,658)	8,455,000	(305,150)	8,149,850			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

LYDIA HEALTHCARE, INC.
0031807
COST REPORT RECLASSIFICATIONS
01/01/00
12/31/00

SCHEDULE V LINE #			
22	EMPLOYEE BENEFITS	41,724	
2	FOOD		41,724

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX	29,658	
19	PROFESSIONAL FEES		29,658

To reclass cost of appealing real estate taxes

Facility Name & ID Number LYDIA HEALTHCARE, INC. #0031807 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation							432,848	432,848			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							720,469	720,469			32
33	Real Estate Taxes			739,345	739,345	29,658	769,003	1,590	770,593			33
34	Rent-Facility & Grounds			2,412,672	2,412,672		2,412,672	(2,412,672)				34
35	Rent-Equipment & Vehicles			14,099	14,099		14,099		14,099			35
36	Other (specify):*							21,299	21,299			36
37	**TOTAL Ownership**			3,166,116	3,166,116	29,658	3,195,774	(1,236,466)	1,959,308			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			226,188	226,188		226,188		226,188			42
43	Other (specify):*	34,604			34,604		34,604	(34,604)				43
44	**TOTAL Special Cost Centers**	34,604		226,188	260,792		260,792	(34,604)	226,188			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,310,371	955,813	6,645,382	11,911,566		11,911,566	(1,576,220)	10,335,346			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number LYDIA HEALTHCARE, INC. # 0031807 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income	(37,461)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(42)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(3,345)	20		19
20	Contributions	(3,030)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(75,286)	21		24
25	Fund Raising, Advertising and Promotional	(6,552)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(38,700)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(228,465)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (392,881)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,183,339)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,183,339)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,576,220)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

LYDIA HEALTHCARE, INC.

ID# 0031807

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance	$	6	1
2	NON ALLOWABLE LEGAL FEES	(573)	19	2
3	REDUCTION OF RELATED PARTY CLER. SAL	(34,604)	43	3
4	VA MEDICAL EXPENSE	(61,091)	10	4
5	LYDIA BUILDING CO. - PROF. FEES	(2,500)	19	5
6	LYDIA BUILDING CO. - BANK CHARGES	(5)	21	6
7	LYDIA BUILDING CO - AMORT. GOODWILL	(13,161)	36	7
8	CAPITALIZED REPAIRS AND MAINTENANCE	(104,451)	6	8
9	MISC. INCOME	(1,805)	21	9
10	DISOUNTS EARNED	(10,275)	21	10
11				11
12				12
13				13
14				14
15				15
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85				85
86				86
87				87
88				88
89				89
90	**Total**	(228,465)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number LYDIA HEALTHCARE, INC. # 0031807 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(42)											(42)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities													5
6	Maintenance	(104,451)											(104,451)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(104,493)											(104,493)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(61,091)											(61,091)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(61,091)											(61,091)	16
	C. General Administration													
17	Administrative													17
18	Directors Fees													18
19	Professional Services	(3,073)	2,500										(573)	19
20	Fees, Subscriptions & Promotions	(12,927)											(12,927)	20
21	Clerical & General Office Expenses	(126,071)	5										(126,066)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar													24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice													26
27	Other (specify):*													27
28	**TOTAL General Administration**	(142,071)	2,505										(139,566)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(307,655)	2,505										(305,150)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number LYDIA HEALTHCARE, INC. # 0031807 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation		432,848										432,848	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(37,461)	757,930										720,469	32
33	Real Estate Taxes		1,590										1,590	33
34	Rent-Facility & Grounds		(2,412,672)										(2,412,672)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*	(13,161)	34,460										21,299	36
37	**TOTAL Ownership**	(50,622)	(1,185,844)										(1,236,466)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(34,604)											(34,604)	43
44	**TOTAL Special Cost Centers**	(34,604)											(34,604)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(392,881)	(1,183,339)										(1,576,220)	45

Facility Name & ID Number LYDIA HEALTHCARE, INC. # 0031807 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
ARNOLD SIMONSEN	100%	WINFIELD WOODS	WINFIELD			
				LYDIA BUILDING		Building Company

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	$ 2,412,672	LYDIA BUILDING		$	$ (2,412,672)	1
2	V	32	INTEREST INCOME	4,015	LYDIA BUILDING			(4,015)	2
3	V	30	DEPRECIATION		LYDIA BUILDING		432,848	432,848	3
4	V	36	AMORTIZATION - GOODWILL		LYDIA BUILDING		13,161	13,161	4
5	V	36	AMORTIZATION - REFINANCING		LYDIA BUILDING		21,299	21,299	5
6	V	32	INTEREST EXPENSE - MORTGAGE		LYDIA BUILDING		761,269	761,269	6
7	V	32	INTEREST EXPENSE - LEASED EQUIP		LYDIA BUILDING		676	676	7
8	V	33	REAL ESTATE TAXES	645,800	LYDIA BUILDING		645,800		8
9	V	33	REAL ESTATE TAXES - P/Y	93,545	LYDIA BUILDING		95,135	1,590	9
10	V	19	PROFESSIONAL FEES		LYDIA BUILDING		2,500	2,500	10
11	V	21	BANK CHARGES		LYDIA BUILDING		5	5	11
12	V								12
13	V								13
14	Total			$ 3,156,032			$ 1,972,693	$ * (1,183,339)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number LYDIA HEALTHCARE, INC. # 0031807 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V						$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number LYDIA HEALTHCARE, INC. # 0031807 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V							$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number LYDIA HEALTHCARE, INC. # 0031807 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V							$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number LYDIA HEALTHCARE, INC. # 0031807 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number LYDIA HEALTHCARE, INC. # 0031807 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number LYDIA HEALTHCARE, INC. # 0031807 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number LYDIA HEALTHCARE, INC. # 0031807 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number LYDIA HEALTHCARE, INC. # 0031807 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

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1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number LYDIA HEALTHCARE, INC. # 0031807 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

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1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number LYDIA HEALTHCARE, INC. # 0031807 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ARNOLD SIMONSEN	ADMINISTRATIVE	ADMINISTRATIV	100.00	SEE ATTACHED	30	75.00	MGMT FEES	$ 1,197,080	17-3	1
2	SUSAN SIMONSEN	ADMINISTRATIVE	ADMINISTRATIV	NONE	SEE ATTACHED	10	20.00	MGMT FEES	26,770	17-3	2
3	CHIP DAUGHERTY	ADMINISTRATIVE	ADMINISTRATIV	NONE	SEE ATTACHED	40	100.00	SALARY	151,871	17-1	3
4	SHARON BRENNAN	CLERICAL	CLERICAL	NONE	0	20	50.00	SALARY	34,603	21-1	4
5	SHARON BRENNAN	CLERICAL	CLERICAL	NONE	0	20	50.00	SALARY	34,604	43-1	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 1,444,928		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.**

Facility Name & ID Number LYDIA HEALTHCARE, INC. # 0031807 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number LYDIA HEALTHCARE, INC. # 0031807 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

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Name of Related Organization
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Phone Number ( )
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	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number LYDIA HEALTHCARE, INC. # 0031807 Report Period Beginning: 01/01/00 Ending: 12/31/00

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1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
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12										12
13										13
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17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number LYDIA HEALTHCARE, INC. # 0031807 Report Period Beginning: 01/01/00 Ending: 12/31/00

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1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
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13										13
14										14
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17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number LYDIA HEALTHCARE, INC. # 0031807 Report Period Beginning: 01/01/00 Ending: 12/31/00

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1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
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21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number LYDIA HEALTHCARE, INC. # 0031807 Report Period Beginning: 01/01/00 Ending: 12/31/00

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1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
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22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number LYDIA HEALTHCARE, INC. # 0031807 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

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1						$	$		$	1
2										2
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4										4
5										5
6										6
7										7
8										8
9										9
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19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number LYDIA HEALTHCARE, INC. # 0031807 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

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	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
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10										10
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17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number LYDIA HEALTHCARE, INC. # 0031807 Report Period Beginning: 01/01/00 Ending: 12/31/00

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1						$	$		$	1
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7										7
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9										9
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17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number LYDIA HEALTHCARE, INC. # 0031807 Report Period Beginning: 01/01/00 Ending: 12/31/00

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1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
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22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number LYDIA HEALTHCARE, INC. # 0031807 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	FIRST CHICAGO		X	MORTGAGE	$83,302.00	11/11/93	$ 11,000,000	$ 9,412,291			$ 761,269	1
2	PLAINSBANK		X	CAPITAL LEASE	$600.00	6/27/98	26,576	9,824	6/27/02	3.9000	676	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$83,902.00		$ 11,026,576	$ 9,422,115			$ 761,945	9
	B. Non-Facility Related*											
10	Supplemental Schedule											10
11	INTEREST INCOME										(37,461)	11
12	REL. PARTY INV. INCOME										(4,015)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (41,476)	14
15	TOTALS (line 9+line14)						$ 11,026,576	$ 9,422,115			$ 720,469	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number LYDIA HEALTHCARE, INC. # 0031807 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$	21

Facility Name & ID Number LYDIA HEALTHCARE, INC. # 0031807 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	481,400	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	576,535	2
3. Under or (over) accrual (line 2 minus line 1).	$	95,135	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	645,800	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$	29,658	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ 113,556 For 19 attach Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	770,593	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	507,332	8
	1996	496,208	9
	1997	443,620	10
	1998	458,420	11
	1999	576,535	12

2000 REAL ESTATE TAX ACCRUAL = $576,535*1.12=$645,800

REAL ESTATE TAX REFUND NOT OFFSET SINCE THE APPLICABLE TAX BILLS WERE NEVER USED TO SET A REAL ESTATE TAX RATE

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number LYDIA HEALTHCARE, INC. # 0031807 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 132,606 B. General Construction Type: Exterior _____ Frame BRICK Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY		1986	$ 26,179	1
2			VARIOUS	79,586	2
3	TOTALS			$ 105,765	3

Facility Name & ID Number LYDIA HEALTHCARE, INC. # 0031807 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	412		1986		$ 3,939,267	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1987	211,048						9
10	Various			1988	225,278						10
11	Various			1989	130,379						11
12	Various			1990	55,561						12
13	Various			1991	72,262						13
14	Various			1992	199,474						14
15	Various			1993	890,967						15
16	Various			1994	168,253						16
17	Various			1995	129,628						17
18	APIC			1996	10,325						18
19	APIC			1996	17,320						19
20	HOH CHEMICALS			1996	1,686						20
21	SANCHEY PAVING			1996	8,000						21
22	SANCHEY PAVING			1996	4,247						22
23	DIRECT SUPPLY			1996	615						23
24											24
25	PAGE 12-1 REP TOTALS				131,203						25
26	PAGE 12J TOTALS				114,696						26
27	PAGE 12I TOTALS				143,592						27
28	PAGE 12H TOTALS				91,486						28
29	PAGE 12G TOTALS				134,830						29
30	PAGE 12F TOTALS				118,961						30
31	PAGE 12E TOTALS				83,318						31
32	PAGE 12D TOTALS				234,755						32
33	PAGE 12C TOTALS				196,865						33
34	PAGE 12B TOTALS				174,626						34
35	PAGE 12A TOTALS				151,024						35
36	TOTAL (lines 4 thru 35)				$ 7,639,666	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number LYDIA HEALTHCARE, INC. # 0031807 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	WATER WORKS			1996	1,205						9
10	AOIC			1996	9,090						10
11	BEST LOCKING			1996	855						11
12	MAGICLEAN			1996	2,663						12
13	WATER WORKS			1996	1,587						13
14	APIC			1996	4,550						14
15	APIC			1996	3,257						15
16	FOREST LUMBER			1996	1,102						16
17	BEST LOCKING			1996	708						17
18	TELEPHONE SYSTEM			1995	17,742						18
19	ECONOCARE			1996	6,222						19
20	ECONOCARE			1996	4,695						20
21	APIC			1996	1,355						21
22	MALCOLITE			1996	949						22
23	FOREST LUMBER			1996	975						23
24	FOREST LUMBER			1996	700						24
25	ROBERTS ENVIRON			1996	46,730						25
26	FLOODLIGHTS			1997	3,900						26
27	CAM LOCKS			1997	537						27
28	MOTOR-HOT W HEATR			1997	774						28
29	BATHROOM REHAB			1997	12,261						29
30	PAINTING			1997	1,985						30
31	LUMBER			1997	810						31
32	SEWER LINE			1997	555						32
33	BATHROOM RPR			1997	1,015						33
34	PLUMBING TILES			1997	12,473						34
35	NURSE STATION			1997	12,329						35
36	TOTAL (lines 4 thru 35)				$ 151,024	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number LYDIA HEALTHCARE, INC. # 0031807 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	REPLACEMENT WINDOWS			1997	33,000						9
10	BATHROOM REHAB			1997	11,120						10
11	SEWER LINE			1997	673						11
12	PLUMBING/TILE RPR			1997	9,000						12
13	LOCKS			1997	514						13
14	PLYWOOD/STUDS			1997	371						14
15	REPLACEMENT WINDOWS			1997	60,000						15
16	SHOWER HOSE			1997	1,204						16
17	REPLACEMENT TILES			1997	539						17
18	LOCKS			1997	634						18
19	BATHROOM FIXTURES			1997	1,656						19
20	PC INSTALLATION			1997							20
21	DRYWALLS			1997	2,239						21
22	PC INSTALLATION			1997							22
23	CALL STATION			1997	2,571						23
24	REPLACEMENT WINDOWS			1997	21,000						24
25	MOTOR			1997	915						25
26	PAINTING & DECORATING			1998	1,269						26
27	FIRE ALARM RPRS			1998	3,338						27
28	NURSE CALL SYS RPRS			1998	1,298						28
29	FIRE ALARM RPRS			1998	2,668						29
30	HVAC REPAIRS			1998	(316)						30
31	SUSPENDED CEILING			1998	2,720						31
32	HVAC REPAIRS			1998	5,398						32
33	PVC WALL BUMPER			1998	913						33
34	WINDOW			1997	6,300						34
35	HVAC RPRS			1998	5,602						35
36	TOTAL (lines 4 thru 35)				$ 174,626	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number LYDIA HEALTHCARE, INC. # 0031807 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	PARKING LOT			1998	4,290						9
10	ROOF			1998	35,000						10
11	VENT/HVAC RPRS			1998	9,739						11
12	SPRINKLER SYS			1998	11,740						12
13	HAND RAIL			1998	454						13
14	PAINTING			1998	1,550						14
15	CHEM FEED SYS			1998	6,570						15
16	SIGNS			1998	2,500						16
17	FRONT RAMP			1998	950						17
18	FIRE ALARM SYS			1998	13,086						18
19	PAINTING & DECOR			1998	2,110						19
20	SUSPENDED CEILING			1998	8,000						20
21	PAINTING & DECORATIN			1998	25,000						21
22	PAINTING & DECOR			1998	(177)						22
23	PAINTING & DECOR			1998	1,547						23
24	PAINTING & DECOR			1998	13,792						24
25	PAINTING & DECOR			1998	5,941						25
26	TOGLE SWITCH			1998	654						26
27	PAINTING & DECOR			1998	683						27
28	PAINTING & DECOR			1998	8,237						28
29	NURSE CALL SYS			1998	5,810						29
30	ALARM SYS			1998	34,575						30
31	PAINTING & DECOR			1998	613						31
32	PAINTING & DECOR			1998	1,007						32
33	PAINTING & DECOR			1998	2,317						33
34	WALLPAPER			1998	250						34
35	NURSE CALL SYS			1998	627						35
36	TOTAL (lines 4 thru 35)				$ 196,865	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number LYDIA HEALTHCARE, INC. # 0031807 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ROOF			1998	85,000						9
10	NEW ROOF			1998	21,043						10
11	SWITCHBD RPRS			1998	1,081						11
12	PAINTING & DECOR			1998	3,425						12
13	SIGNS			1998	3,020						13
14	TOILET RPRS			1998	1,905						14
15	DOORS			1998	20,000						15
16	ALLEY REPAIR			1998	650						16
17	TOILET RPRS			1998	1,845						17
18	HVAC RPRS			1998	624						18
19	WATER PUMP RPR			1998	2,240						19
20	CEILING HEATER			1998	992						20
21	CEILING TILES			1998	524						21
22	PAINTING & DECOR			1998	(182)						22
23	NURSE CALL SYS			1998	1,068						23
24	LAWN SPRINKLER RPRS			1998	581						24
25	HVAC REPAIRS			1998	747						25
26	HMS			1999	12,144						26
27	PAINT/WALLPAPER			1999	1,265						27
28	INSTALL FIRE DAMPERS			1999	51,500						28
29	WALLPAPER			1999	1,210						29
30	WALLPAPER			1999	3,591						30
31	CROWN MOLDING			1999	6,452						31
32	CROWN MOLDING			1999	4,359						32
33	FLOOR TILE			1999	560						33
34	BOILER-CORR PER CODE			1999	4,000						34
35	WALLPAPER			1999	5,111						35
36	TOTAL (lines 4 thru 35)				$ 234,755	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number LYDIA HEALTHCARE, INC. # 0031807 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	PAINT			1999	507						9
10	WALLCOVERING			1999	12,210						10
11	PAINT WALLS			1999	13,162						11
12	WALLPAPER			1999	5,251						12
13	BLINDS			1999	1,206						13
14	WALLPAPER			1999	7,848						14
15	TOILET			1999	508						15
16	WALLPAPER			1999	1,102						16
17	PAINT WALL			1999	2,467						17
18	PAINT			1999	2,362						18
19	PAINT WALLS/CHAIR LF			1999	3,580						19
20	LOCKS			1999	566						20
21	LUMBER			1999	599						21
22	PAINT WALLS			1999	748						22
23	WALLPAPER			1999	897						23
24	WALLPAPER			1999	1,196						24
25	PAINT WALLS			1999	805						25
26	BLINDS			1999	2,481						26
27	WALLPAPER			1999	6,653						27
28	CARPET/TILE			1999	3,918						28
29	CROWN MOLDING			1999	3,065						29
30	PAINT/WALLPAPER			1999	1,081						30
31	PAINT/WALLPAPER			1999	8,135						31
32	PAINT/WALLPAPER			1999	1,070						32
33	CARPET			1999	635						33
34	WALLPAPER			1999	732						34
35	VINYL TILE			1999	534						35
36	TOTAL (lines 4 thru 35)				$ 83,318	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number LYDIA HEALTHCARE, INC. # 0031807 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	NEW PHONE EXT			1999	905						9
10	CROWN MOLDING			1999	10,465						10
11	CROWN MOLDING			1999	10,465						11
12	NURSE CALL SYSTEM			1999	1,630						12
13	BOWL DIFFUSER			1999	1,189						13
14	COVE BASE			1999	1,460						14
15	PAINT BORDER			1999	2,467						15
16	FLOWERING FLAT			1999	503						16
17	ANDERSON LOCK			1999	566						17
18	PAINT/WALLPAPER			1999	14,939						18
19	WALL PLAQUES SIGN			1999	2,204						19
20	CROWN MOLDING			1999	6,547						20
21	PAINT WALLS			1999	13,162						21
22	CROWN MOLDING			1999	6,547						22
23	CARPETING			1999	612						23
24	CROWN MOLDING			1999	3,065						24
25	BORDER PAPER			1999	688						25
26	HMS			1999	9,895						26
27	VINYL WALLCOVERING			1999	9,453						27
28	BLINDS			1999	1,206						28
29	BLINDS			1999	1,206						29
30	WALLPAPER			1999	717						30
31	BORDER PAPER			1999	2,475						31
32	CROWN MOLDING			1999	3,065						32
33	PAINT/WALLPAPER			1999	8,137						33
34	CROWN MOLDING			1999	3,734						34
35	WALLPAPER			1999	1,659						35
36	TOTAL (lines 4 thru 35)				$ 118,961	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number LYDIA HEALTHCARE, INC. # 0031807 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	WALL PLAQUES SIGN			1999	2,203						9
10	HMS			1999	4,465						10
11	WALL BUMPER			1999	4,843						11
12	WALL PLAQUES SIGN			1999	2,204						12
13	WALLPAPER			1999	4,902						13
14	CHAIR RAR/COVE BASE			1999	1,113						14
15	RUBBER COVE BASE			1999	190						15
16	WALL BUMPER			1999	4,843						16
17	CROWN MOLDING			1999	3,625						17
18	VINYL WALLCOVERING			1999	4,876						18
19	INSTALL DATA CABLE			1999	3,325						19
20	WALLPAPER			1999	6,027						20
21	WALL PLAQUES/SIGN			1999	2,204						21
22	NTC			1999	38,018						22
23	PAVING			1999	5,400						23
24	SEXAUER			1999	815						24
25	BULLETIN BOARDS			1999	1,621						25
26	PAINT WALLS/DOOR FRAME			1999	2,386						26
27	PAINTING			1999	7,533						27
28	PAINT WALL/BLINDS			1999	13,559						28
29	CROWN MOLDING			1999	10,465						29
30	DRYWALL			1999	550						30
31	DOOR SWITCH			1999	634						31
32	NURSE CALL SYS REPAIR			1999	1,006						32
33	WOOD CHAIR RAIL			1999	1,113						33
34	WATER TREATMENT			1999	5,110						34
35	AIR HANDLING UNIT RPRS			1999	1,800						35
36	TOTAL (lines 4 thru 35)				$ 134,830	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number LYDIA HEALTHCARE, INC. # 0031807 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	WALLPAPER			1999	753						9
10	PLUMBING			1999	1,809						10
11	SPRINKLER			1999	2,016						11
12	PLATE GLASS			1999	550						12
13	HVAC REPAIRS			1999	1,787						13
14	HVAC REPAIRS			1999	604						14
15	FIRE SYSTEM			1999	819						15
16	FIRE SYSTEM			1999	505						16
17	FIRE DAMPER			1999	250						17
18	WALLCOVERING-19934			2000	9,329						18
19	WALLCOVERING-19963			2000	10,143						19
20	WALLCOVERING-20074			2000	920						20
21	WALLCOVERING-19950			2000	9,373						21
22	WALLCOVERING-19909			2000	11,845						22
23	WALLCOVERING-19910			2000	1,194						23
24	WALLCOVERING-19916			2000	4,821						24
25	WALLCOVERING-19928			2000	536						25
26	WALLCOVERING-19933			2000	2,022						26
27	WALLCOVERING-20140			2000	9,488						27
28	WALLCOVERING-19935			2000	349						28
29	WALLCOVERING-19936			2000	1,986						29
30	WALLCOVERING-19937			2000	9,239						30
31	WALLCOVERING-20003			2000	1,294						31
32	WALLCOVERING-19947			2000	6,210						32
33	WALLCOVERING-19978			2000	1,206						33
34	WALLCOVERING-19951			2000	2,300						34
35	WALLCOVERING-19952			2000	138						35
36	TOTAL (lines 4 thru 35)				$ 91,486	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number LYDIA HEALTHCARE, INC. # 0031807 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	WALLCOVERING-19958			2000	3,099						9
10	WALLCOVERING-19960			2000	1,813						10
11	WALLCOVERING-19959			2000	1,280						11
12	WALLCOVERING-19999			2000	6,653						12
13	WALLCOVERING-19892			2000	6,547						13
14	WALLCOVERING-20076			2000	13,363						14
15	PHOTO CELL			2000	2,352						15
16	WALLCOVERING-19507			2000	396						16
17	WALLCOVERING-20004			2000	259						17
18	WALLCOVERING-19998			2000	3,506						18
19	PAVING - 101234			2000	12,622						19
20	WALLCOVERING-20024			2000	7,533						20
21	WALLCOVERING-20025			2000	2,386						21
22	WALLCOVERING-20143			2000	9,470						22
23	WALLCOVERING-20073			2000	58						23
24	WALLCOVERING-20139			2000	9,488						24
25	WALLCOVERING-20075			2000	7,120						25
26	WALLCOVERING-19979			2000	629						26
27	WALLCOVERING-20077			2000	1,194						27
28	WALLCOVERING-20078			2000	12,297						28
29	WALLCOVERING-20079			2000	12,297						29
30	WATER HEATER			2000	6,850						30
31	WALLCOVERING-20126			2000	4,688						31
32	WALLCOVERING-20127			2000	984						32
33	WALLCOVERING-20128			2000	2,263						33
34	WALLCOVERING-20035			2000	12,500						34
35	HEATER INSTALL			2000	1,945						35
36	TOTAL (lines 4 thru 35)				$ 143,592	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number LYDIA HEALTHCARE, INC. # 0031807 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	9TH FLOOR RENOVATION			2000	29,156						9
10	DOOR LOCK			2000	574						10
11	WALLCOVERING-200100			2000	4,589						11
12	WALLCOVERING-20168			2000	10,971						12
13	WALLCOVERING-20169			2000	350						13
14	WALLCOVERING-19891			2000	3,734						14
15	WALLCOVERING-20089			2000	6,221						15
16	WALLCOVERING-19893			2000	3,734						16
17	WALLCOVERING-19976			2000	10,465						17
18	NEW DOORS			2000	8,287						18
19	WALLCOVERING-20162			2000	1,532						19
20	WALLCOVERING-20193			2000	12,506						20
21	TOILET			2000	871						21
22	FIRE ALARM			2000	502						22
23	4 WATERFLOW"			2000	635						23
24	TILE			2000	900						24
25	SOUND SYSTEM			2000	965						25
26	LIGHTING FIXTURE COV			2000	874						26
27	DOOR LOCKS			2000	577						27
28	BOOSTER HEATER			2000	1,840						28
29	WALLCOVERING-19894			2000	6,547						29
30	FENCE & GATE			2000	995						30
31	WALLCOVERING-19938			2000	392						31
32	DRAPERIES			2000	5,500						32
33	FIRE ALARM			2000	537						33
34	SOLENOID			2000	860						34
35	FLOORING			2000	582						35
36	TOTAL (lines 4 thru 35)				$ 114,696	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number LYDIA HEALTHCARE, INC. # 0031807 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	MAXITROL VALUE			2000	999						9
10	UNIT HEATER MOTOR			2000	795						10
11	HEATER MOTOR			2000	878						11
12	ALARM SYSTEM			2000	2,203						12
13	WALLCOVERING-20032A			2000	4,589						13
14	CLOSED CIRCUIT			2000	4,057						14
15	WALLCOVERING-20141			2000	2,530						15
16	R & W HEATING			2000	1,130						16
17	HMS BLINDS			2000	4,135						17
18	9TH FLOOR RENOVATION			2000	32,896						18
19	R & W HEATING			2000	5,650						19
20	SIGMA			2000	33,000						20
21	9TH FLOOR			2000	30,000						21
22	FLOORING			2000	4,525						22
23	AIR CONDITIONING			2000	1,059						23
24	WALLCOVERING-19977			2000	1,206						24
25	BLINDS			2000	1,551						25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 131,203	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number LYDIA HEALTHCARE, INC. # 0031807 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number LYDIA HEALTHCARE, INC. # 0031807 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 505,381	$	$	$		$	37
38	Current Year Purchases	131,336						38
39	Fully Depreciated Assets	453,765						39
40								40
41	TOTALS	$ 1,090,482	$	$	$		$	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	FACILITY BUSINESS	95 PLYMOUTH VOYAGER	1995	$ 18,461	$	$	$	5	$	42
43	FACILITY BUSINESS	1997 VEHICLE	1997	33,528				10		43
44	FACILITY BUSINESS	CHEVY TRUCK	1998	29,076				10		44
45										45
46	TOTALS			$ 81,065	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 8,916,978	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 432,834	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 432,834	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	1989 FORD VAN	$ 7,000	$ 807	$ 6,597	52
53					53
54					54
55					55
56					56
57	TOTALS	$ 7,000	$ 807	$ 6,597	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

LYDIA HEALTHCARE, INC.
0031807
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
12/31/00

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
LINE 28: PRIOR YEARS					
	523,698				
TOTALS	523,698				
LINE 29: CURRENT YEAR					
TOTALS					
LINE 30: FULLY DEPRECIATED					
TOTALS					
TOTALS (Should Tie to Totals on Page 13)					
	523,698				
TOTALS	523,698				

Facility Name & ID Number LYDIA HEALTHCARE, INC. # 0031807 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ 9,483 Description: SEE ATTACHED
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ADMINISTRATIVE	1997 LUMINA	$ 386.66	$ 4,616	17
18					18
19					19
20					20
21	TOTAL		$ 386.66	$ 4,616	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number LYDIA HEALTHCARE, INC. # 0031807 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs		$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs								2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs								4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescrpts								9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify): **SEE SUPPLEMENTAL SCHEDULE**										13
14	TOTAL				$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

	Special Services - Supplies (Column 6 - Other)	Amount
1	Medical Supplies	
2	Complex Medical Equip	
3	Oxygen	
4	Equipment Rental	
5		
6		
7		
8		
9		
10		

	Outside Therapies (Column 5 - Other)	Amount
1	Respiratory Therapy	
2		
3		
4		
5		
6		
7		
8		
9		
10		

Facility Name & ID Number LYDIA HEALTHCARE, INC. # 0031807 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (165,101)	$ 458,800	1
2	Cash-Patient Deposits	28,259	28,259	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,158,180	2,158,180	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	27,805	27,805	6
7	Other Prepaid Expenses	4,224	4,224	7
8	Accounts Receivable (owners or related parties)	4,732,181	605,828	8
9	Other(specify): See supplemental schedule			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 6,785,548	$ 3,283,096	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		105,765	13
14	Buildings, at Historical Cost		6,871,530	14
15	Leasehold Improvements, at Historical Cos		2,537,701	15
16	Equipment, at Historical Cost		1,511,674	16
17	Accumulated Depreciation (book methods)		(5,186,986)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):		90,352	22
23	Other(specify): See supplemental schedule		11,545	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$ 5,941,581	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,785,548	$ 9,224,677	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 542,107	$ 542,107	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	28,260	28,260	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	138,706	138,706	30
31	Accrued Taxes Payable (excluding real estate taxes)	32,528	32,528	31
32	Accrued Real Estate Taxes(Sch.IX-B)		645,800	32
33	Accrued Interest Payable		62,686	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	87,219	87,219	35
	Other Current Liabilities(specify):			
36	See supplemental schedule			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 828,820	$ 1,537,306	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		9,824	39
40	Mortgage Payable		9,668,716	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 9,678,540	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 828,820	$ 11,215,846	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 5,956,728	$ #REF!	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,785,548	$ #REF!	48

*(See instructions.)

Facility Name & ID Number LYDIA HEALTHCARE, INC. **#** 0031807 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES **As of** 12/31/00

OTHER CURRENT ASSETS:	Amount	Amount	OTHER CURRENT LIABILITIES:	Amount	Amount
Real Estate Tax Escrow			Accrued Expenses		
			Accrued R. E. Tax - Non Care Property		
OTHER NON CURRENT ASSETS:			OTHER NON CURRENT LIABILITIES:		
Construction In Progress		11,545			
Utility Deposit					
Loan Costs					
		11,545			

Facility Name & ID Number LYDIA HEALTHCARE, INC. # 0031807 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 5,486,288	1
2	Restatements (describe):		2
3	Schedule attached	(126,998)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 5,359,290	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,447,438	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,850,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 597,438	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 5,956,728	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number	LYDIA HEALTHCARE, INC.	#	0031807	Report Period Beginning:	01/01/00	Ending:	12/31/00

Balance per General Ledger		5,359,290
Adjustments:		
		-
		-
		-
INCREASE IN BAD DEBT RESERVE POST CR FILING PY		126,998
Total adjustments		126,998
Balance - Beginning of Year		5,486,288
Equity(Deficit) from Page 17 Col 1		5,956,728
Related Party		
Equity(Deficit)	-9132831	
Income	1184934	
		(7,947,897)
Combined Equity - End of Year		(1,991,169)

Facility Name & ID Number LYDIA HEALTHCARE, INC. # 0031807 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 14,309,463	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 14,309,463	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	37,461	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 37,461	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	12,080	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 12,080	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 14,359,004	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,465,783	31
32	Health Care	3,036,039	32
33	General Administration	2,982,836	33
	B. Capital Expense		
34	Ownership	3,166,116	34
	C. Ancillary Expense		
35	Special Cost Centers	34,604	35
36	Provider Participation Fee	226,188	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,911,566	40
41	**Income before Income Taxes (line 30 minus line 40)****	2,447,438	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 2,447,438	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number **LYDIA HEALTHCARE, INC.** **# 0031807** **Report Period Beginning:** **01/01/00** **Ending:** **12/31/00**

SUPPLEMENTAL SCHEDULE OF REVENUES
12/31/00

	DESCRIPTION	AMOUNT
1	MISC. INCOME	1,805
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
	TOTALS	1,805

Facility Name & ID Number LYDIA HEALTHCARE, INC. # 0031807 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,872	2,223	$ 71,240	$ 32.05	1
2	Assistant Director of Nursing	2,714	5,260	95,043	18.07	2
3	Registered Nurses	1,268	1,281	20,391	15.92	3
4	Licensed Practical Nurses	61,681	64,193	1,062,016	16.54	4
5	Nurse Aides & Orderlies	120,860	136,269	968,873	7.11	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	27,148	28,177	172,443	6.12	10
11	Social Service Workers	21,570	22,519	371,149	16.48	11
12	Dietician					12
13	Food Service Supervisor	2,302	2,374	31,783	13.39	13
14	Head Cook					14
15	Cook Helpers/Assistants	38,222	41,257	295,815	7.17	15
16	Dishwashers					16
17	Maintenance Workers	7,887	8,696	110,695	12.73	17
18	Housekeepers	59,666	63,939	445,017	6.96	18
19	Laundry	7,038	7,633	46,869	6.14	19
20	Administrator	2,000	2,080	151,871	73.01	20
21	Assistant Administrator	2,000	2,080	53,022	25.49	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	27,561	29,294	366,765	12.52	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	627	675	6,368	9.43	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	627	675	6,408	9.49	31
32	Other Health Care(specify)					32
33	Other(specify)	2,602	2,768	34,604	12.50	33
34	TOTAL (lines 1 - 33)	387,645	421,393	$ 4,310,372 *	$ 10.23	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	370	$ 14,078	01-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	1,950	10-3	39
40	Physical Therapy Consultant	43	2,351	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	1,829	31,102	11-3	44
45	Social Service Consultant	645	19,306	12-3	45
46	Other(specify) dental	monthly	2,700	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,887	$ 71,487		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	4,449	71,187	10-3	52
53	TOTAL (lines 50 - 52)	4,449	$ 71,187		53

Facility Name & ID Number LYDIA HEALTHCARE, INC. # 0031807 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Related Party Clerical	2,602	2,768	$ 34,604	$ 12.50
	2,602	2,768	$ 34,604	$ 12.50

Facility Name & ID Number LYDIA HEALTHCARE, INC. # 0031807 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
CHIP DAUGHERTY	ADMINISTRATOR		$ 151,871
MARCITA CARTER	ASST. ADMIN		53,022
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 204,893

B. Administrative - Other

Description	Amount
SIMONSEN, INC.	$ 1,197,080
SUSAN SIMONSEN	26,770
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,223,850
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
FROST, RUTTEBBERG	ACCOUNTING	$ 49,567
MIS	DATA PROCESSING	4,726
FROST, RUTTENBERG	DATA PROCESSING	21,200
SENIOR LIVING SYSTEMS	DATA PROCESSING	8,493
MICROSHARE	DATA PROCESSING	1,266
KRONOS	DATA PROCESSING	938
SEE ATTACHED	LEGAL	37,513
PAYCHEX	PAYROLL PROCESSING	5,058
ECONOCARE	PURCHASING CONSUL.	2,826
PERSONNEL PLANNERS	UNEMPLOYMENT CONSUL.	2,440
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 134,027

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 62,627
Unemployment Compensation Insurance	77,718
FICA Taxes	329,743
Employee Health Insurance	146,409
Employee Meals	41,724
Illinois Municipal Retirement Fund (IMRF)*	
RETIREMENT PLAN	51,961
UNION HEALTH AND WELFARE	42,910
EMPLOYEE BENEFITS	8,751
EMPLOYEE PHYSICALS	3,159
TOTAL (agree to Schedule V, line 22, col.8)	$ 765,002

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	17,583
Health Care Worker Background Check	
(Indicate # of checks performed)	
IL COUNCIL ON LTC	16,150
DUES AND SUBSCRIPTIONS	660
LICENSES AND INSPECTIONS	1,295
Less: Public Relations Expense	(710)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 34,978

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,009
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,009

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number LYDIA HEALTHCARE, INC. # 0031807 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number LYDIA HEALTHCARE, INC. # 0031807 Report Period Beginning: 01/01/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **Illinois Council on LTC $16,150**

(3) Did the nursing home make political contributions or payments to a politica action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YRS.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **N/A** Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen of Public Aid during this cost report period. $ **226,188**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classifiec in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services fo the patient census listed on page 2, Section B? **N/A** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. $ **41,724** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%:L14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all othe times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjustec out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Date: **07/17/2000**

To: **Administrator/Cost Report Preparer**

From: **Office of Health Finance**

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to b entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "A Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu ba after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use Fi Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been seale you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can g to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/cw